Medicaid Basics and Indiana Health Coverage Programs (IHCPs)

Module #2
Training Resource for
Indiana Navigators

Module #2 Objectives

- After reviewing this module, you will be able to:
  - Assess whether someone *might be* eligible for Medicaid
  - Tell a consumer what information he or she will need to provide as a part the Medicaid application
  - Explain consumer options to apply for health coverage through the State
  - Help a consumer know what to expect after the application is filed

What is Medicaid?

- Funded by state and federal government
- Provides free or low-cost health insurance to low-income:
  - Children
  - Parents and caretakers
  - Pregnant women
  - Aged
  - Blind
  - Disabled
- Offer many different programs
  - Eligibility criteria varies by group

Current Indiana Health Coverage Programs (IHCPs)

As of 2014, Indiana offers a variety of health coverage programs, including:

- Hoosier Healthwise,
- Healthy Indiana Plan (HIP),
- Care Select,
- Traditional Medicaid,
- Medicaid for Employees with Disabilities (M.E.D. Works),
- Home and Community-Based Service Waivers,
- Medicare Savings Program,
- Family Planning Eligibility Program,
- Breast and Cervical Cancer Program

Each of these programs serves a unique population with different eligibility requirements, detailed in the following slides.

Hoosier Healthwise

- Covered populations:
  - Low-income families
  - Pregnant women
  - Children under 19 years old
    - Medicaid
      - Created for children of low-income households
    - Children's Health Insurance Program (CHIP)
      - Created for children with family income too high to qualify for Medicaid

Hoosier Healthwise Income Limits*

Monthly income limit for different groups covered by Hoosier Healthwise

Family Size	Parents & Caretaker Relatives	Children	Pregnant Women
1	n/a	$2,432	n/a
2	$247	$3,278	$2,727
3	$310	$4,123	$3,431
4	$373	$4,969	$4,134
5	$435	$5,815	$4,838

*Income limits effective 3/1/14 – amounts updated annually

Healthy Indiana Plan (HIP)

- **Goal:**
  - Provides low-cost health insurance
- **Eligibility:**
  - Uninsured adults
  - Age 19-64
  - Up to 100%* FPL
- **Program features:**
  - Basic commercial benefits plan
  - Annual deductible
    - $1,100 per year
  - $500 in preventive services covered by State
  - Co-pays for non-emergency use of Emergency Room
  - Personal Wellness and Responsibility (POWER) Account
    - Funds $1,100 annual deductible
    - State and individual contribute funds to account
      - **Individual contributes no more than 2% of income each month**
    - Employers & nonprofits may help individual with their contributions

*$973 per month for family size of 1 (2014 FPL Standard)

Managed Care Entities (MCEs):
Hoosier Healthwise (HHW) & Healthy Indiana Plan (HIP)

Anthem

MDwise

mhs
Your Choice for Better Healthcare

- **Indiana contracts with three MCEs to administer HHW and HIP**
- **Goal:**
  - Integrate programs for a seamless healthcare experience for families
- **Selecting a MCE:**
  - Individuals select at application OR
  - Individuals auto-assigned 14 days after enrollment
- **Selecting a doctor after MCE enrollment:**
  - Individuals select a Primary Medical Provider (PMP) OR
  - Individuals assigned a PMP

Care Select

This program is scheduled to be in effect until 1/1/15 at which time enrollees will be transitioned to a new coordinated care program

- **Covered population:**
  - Indiana Medicaid enrollees with special health needs or chronic illnesses
  - Enrollees eligible for Medicaid because:
    - Aged
    - Blind
    - Disabled
    - Ward of the court
    - Foster child
    - Child receiving adoption services or assistance
- **Goal:**
  - Care coordination & management
  - Disease management
- **Process - Enrollees select or are assigned to:**
  - Care Management Organization (CMO)
    - Oversee and coordinate care
  - Primary Medical Provider (PMP)
    - Provide direct health care & referrals to specialty care

Examples of qualifying conditions:

- Asthma
- Diabetes
- Congestive Heart Failure
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Hypertension
- Chronic kidney disease (no dialysis)
- Severe Mental Illness
- Severe Emotional Disturbance
- Depression
- Any other serious and chronic medical condition, as approved by OMPP

Traditional Medicaid

- Enrollee can seek care from any Medicaid provider
- Covered populations:
  - Aged, blind, and disabled
    - Dual eligible (Medicare and Medicaid recipients)
    - Nursing home care and other institutions
    - Hospice services
    - Medicaid for Employees with Disabilities (M.E.D. Works)
  - Adults
    - Recipients of waiver services
    - Medicaid eligible due to breast or cervical cancer
  - Children
    - In psychiatric facilities
    - Title IV-E Foster care and adoption assistance
    - Former foster children up to age 21
    - Former foster children up to age 26 who were enrolled in Medicaid as of their 18th birthday
  - Refugees who do not qualify for another aid category

Medicaid for Employees with Disabilities (M.E.D. Works)*

	Monthly Income	Premium
Single	$1,459 - $1,702	$48
	$1,703 - $1,945	$69
	$1,946 - $2,432	$107
	$2,433 - $2,918	$134
	$2,919 - $3,404	$161
	$3,405	$187
Married	$1,967 - $2,294	$65
	$2,295 - $2,622	$93
	$2,623 - $3,278	$145
	$3,279 - $3,933	$182
	$3,934 - $4,588	$218
	$4,589	$254
Based on 2014 FPL - amounts adjusted annually		

- **Covered population:**
  - Working people with disabilities
- **Eligibility criteria:**
  - Age 16-64
  - Less than or equal to 350% Federal Poverty Level (FPL)
  - Disabled
  - Below asset limit
    - Single: $2,000
    - Couple: $3,000
  - Working
- **Benefits:**
  - Full Medicaid benefits
  - May have employer insurance**

*Must apply through Indiana Application for Health Coverage
**Medicaid is the secondary payer

Home & Community-Based Service (HCBS) Waivers

- **Covered population:**
  - Would otherwise require institutionalized care
- **Goal:**
  - Keep individual in home & community setting
  - Avoid need to go to institution (i.e. nursing home)
- **Eligibility:**
  - Income less than or equal to 300% of the maximum Supplemental Security Income (SSI) federal benefit rate
    - $2,163/month
      - If income exceeds this threshold a member may establish a Miller Trust
    - If under age 18: Does not include parental income or resources
  - Meets "Level of Care"
    - Example: Complex medical condition, intellectual disability

Medicare Savings Program

- **Covered population:**
  - Low-income Medicare beneficiaries
- **Goal:**
  - Help pay for out-of-pocket Medicare costs
- **Eligibility:**
  - Must be eligible for Medicare Part A
  - Four potential categories depending on income and worker status

Medicare Savings Program, cont.*

	Income Threshold**	Resource Limit	Benefits
QMB (Qualified Medicare Beneficiary)	150% Federal Poverty Level (FPL) Single: $1,459/month Married: $1,967/month	• Single: $7,160 • Couple: $10,750	• Medicare Premiums • Co-pays • Deductibles • Coinsurance
SLMB (Specified Low-Income Medicare Beneficiary)	170% FPL (Single: $1,654/month Married: $2,229/month)	• Single: $7,160 • Couple: $10,750	• Part B Premiums
QI (Qualified Individual)	185% FPL (Single: $1,800/month Married: $2,426/month)	• Single: $7,160 • Couple: $10,750	• Part B Premiums
QDW*** (Qualified Disabled Worker)	200% FPL (Single: $1,945/month Married: $2,622/month)	• Single: $7,160 • Couple: $10,750	• Part A Premium

*Apply through Indiana Application for Health Coverage (IAHC) ** Effective 6/1/14 ***Lost Medicare Part A coverage due to working status

Family Planning Services for Women and Men

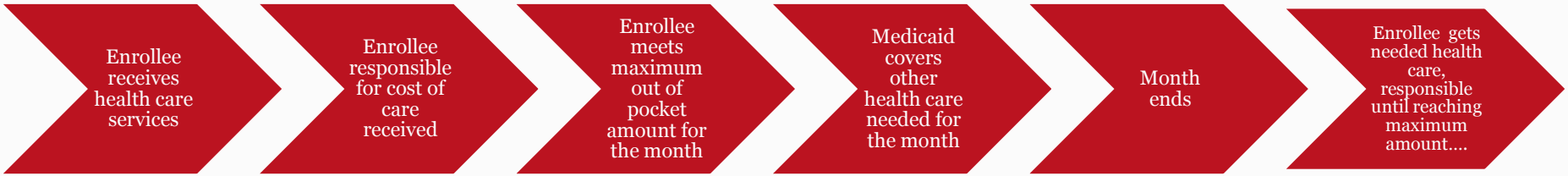
- **Goal:**
  - Pregnancy prevention/delay
  - Provide family planning services and supplies
- **Eligibility:**
  - Do not qualify for any other Medicaid category*
  - Income at or below 141%** Federal Poverty Level (FPL)
  - Citizenship/immigration eligibility requirements
  - Not pregnant
  - Have not had hysterectomy (removal of uterus)
  - Have not had sterilization procedure

*Women losing other Medicaid coverage after the birth of a child are automatically assessed for eligibility
**$1,372 per month for family size of 1 (2014 FPL Standard); $1,849 per month for a family size of 2

Spend-Down

Effective June 1, 2014, the spend-down program will be discontinued.

- **Goal:**
  - To assist individuals who have high medical needs but do not meet Medicaid income eligibility requirements
- **Eligibility:**
  - Income is too high to qualify for Medicaid
  - Meet other Medicaid criteria due to:
    - Age
    - Blindness
    - Disability
- **Process:**



Breast and Cervical Cancer Program

- **Goal:**
  - Provide Medicaid coverage to women with breast or cervical cancer
- **Eligibility:**
  - Diagnosed through Indiana State Department of Health Breast & Cervical Cancer Screening Program

  -OR-
  - Age 19-64
  - Not otherwise eligible for Medicaid
  - Income less than 200% FPL*
  - Need treatment for breast or cervical cancer
  - No health insurance that covers their treatment

*$1,945 per month for family size of 1; $2,622 for a family size of 2 (2014 FPL Standard)

Summary of Medicaid Programs: Hoosier Healthwise (HHW)

<table>
<tr><th>Description</th><th colspan="2">Income Limit</th><th>Age Requirement</th><th>Other Requirements</th></tr>
<tr><td rowspan="3">Children</td><td colspan="2">Up to 250% FPL
($3,278/month for a family of 2 in 2014
$4,969/month for a family of 4 in 2014)</td><td>0-18 year old</td><td>N/A</td></tr>
<tr><td>Household Size</td><td>Monthly Income</td><td rowspan="2">19-20 years old</td><td rowspan="2">N/A</td></tr>
<tr><td>1
2
3
4
5</td><td>$152
$247
$310
$373
$435</td></tr>
<tr><td>Parents & Caretaker Relatives</td><td colspan="2">See Children: 19-20 years old</td><td>N/A</td><td>Parent or caretaker of dependent child</td></tr>
<tr><td>Pregnant Women</td><td colspan="2">Up to 208% FPL
($2,727 per month for a pregnant woman in 2014
$4,134 for a pregnant woman with 2 children in 2014)</td><td>N/A</td><td>Pregnant</td></tr>
</table>

Traditional Medicaid Program Summary

Description	Income Limit	Age Requirement	Other Requirements
Aged Blind Disabled	Effective 6/1/14: Up to 100% FPL[1] Single: $973/month Married: $1,311/month	**Aged:** 65 years old or older **Blind:** N/A **Disabled:** N/A	**Blind & Disabled:** Has received a disability determination from Social Security Administration (SSA) related to determination of blindness or disability – *or*- has received MRT determination and applied for SSA benefits within 45 days of Medicaid application
Home & Community-Based Services Waivers & Institutional Care	Up to 300% Supplemental Security Income (SSI) benefit[1,2]	N/A	Meets "Level of Care" needs (must require long-term care services)
Breast & Cervical Cancer Program	Up to 200%FPL Single: $1,945/month Married: $2,622/month	18-64 years old	Diagnosed with breast and/or cervical cancer Cannot qualify for any other Medicaid category No health insurance that covers cancer treatment
M.E.D. Works[3]	Up to 350% FPL[1] $3,406/month	16-64 years old	Meets definition of disability as described above

1) Resource limits also apply –2) $2,163/month, as of 2014. If income exceeds 300% of the SSI benefit, can establish a Miller trust to retain eligibility– 3) Medicaid for the Working Disabled

Traditional Medicaid Program Summary, cont.

Description	Income Limit		Age Requirement	Other Requirements
Children – Psychiatric Facility	Household Size 1 2 3 4 5	Monthly Income $152 $247 $310 $373 $435	19-21* years old	Inpatient at a Medicaid certified psychiatric facility
Children – Adoption Assistance	N/A		Under age 19	Receiving adoption assistance
Children – Foster Children	N/A		Under age 19, some eligible through 20	Current foster child
Former Foster Children	Up to 210% FPL Individual: $2,043/month		18-21 years old	N/A
	N/A		18-25 years old	Enrolled in Medicaid as of 18th birthday**
Refugee	Household Size 1 2 3 4 5	Monthly Income $139 $229 $288 $346 $405	N/A	N/A

*If approved for Medicaid before 21st birthday, can remain on Medicaid until age 22 if still in psychiatric facility

**New eligibility group created by the Affordable Care Act

Summary of Medicaid Programs: Other Available Coverage

Name of program	Description	Income Limit	Age Requirement	Other Requirements
Healthy Indiana Plan	Adults	100% FPL	19-64 years old	N/A
Care Select	Disease Management & Care Coordination	Varies by Eligibility Category	N/A	Qualifying medical condition
Family Planning	Family Planning	Up to 141% FPL	N/A	Cannot qualify for any other Medicaid category
Medicare Savings Program	QMB[2]	150% FPL[1,6]	N/A	Qualifies for Medicare Part A
	SLMB[3]	170%FPL[1,6]	N/A	Qualifies for Medicare Part A
	QI[4]	185% FPL[1,6]	N/A	Qualifies for Medicare Part A
	QDW[5]	200% FPL[1,6]	N/A	Lost Medicare Part A coverage due to employment status

1) Resource limits also apply
2) Qualified Medicare Beneficiary
3) Specified Low-Income Medicare Beneficiary
4) Qualified Individual
5) Qualified Disabled Worker
6) Income thresholds effective 6/1/14

General Medicaid Eligibility Factors and Verification Requirements

Eligibility factors that apply for any type of Indiana Health Coverage Program (IHCP)

General Medicaid Eligibility Factors and Requirements

- Age
- Income
- Indiana Resident
- Citizenship/Immigration Status
- Provide Social Security Number (SSN)
- Provide information on other insurance coverage
- File for other benefits

Requirement: Citizenship, Immigration Status

- **Eligibility:**
  - U.S. citizens
  - U.S. non-citizen nationals
  - Immigrants with qualified immigration status
    - Lawful permanent residents eligible for full Medicaid after 5 years
- **Exemptions (do not need to verify citizenship):**
  - Medicare enrollees
  - Foster care children
  - Receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)
  - Newborns with a mother enrolled in Medicaid

Requirement: Provide a Social Security Number

- Individuals **must** supply a Social Security number (SSN), **unless**:
  - Not eligible to receive a SSN
  - Do not have a SSN and may only be issued one for a valid non-work reason
  - Refuse to obtain SSN due to well-established religious objections
  - Only eligible for emergency services due to immigration status
  - A newborn baby with mother on Medicaid
  - Receiving Refugee Cash Assistance (RCA), eligible for Medicaid
  - Have already applied for a SSN

Requirement: File for other benefits

- **Individuals must apply for other benefits if they may be eligible, including:**
  - ❑ Pensions from local, state, or federal government
  - ❑ Retirement benefits
  - ❑ Disability
  - ❑ Social Security benefits
  - ❑ Veterans' benefits
  - ❑ Unemployment compensation benefits
  - ❑ Military benefits
  - ❑ Railroad retirement benefits
  - ❑ Worker's compensation benefits
  - ❑ Health and accident insurance payments

Requirement: Report and use other insurance

- **Applicants may:**
  - Have other insurance
    - Exceptions: Children's Health Insurance Program (CHIP) & Healthy Indiana Plan (HIP)
- **Applicants must**:
  - Provide information about other insurance
    - On application
    - After a change in insurance status
- **Why it is important to report other insurance:**
  - Applicants must use other insurance first
  - Medicaid pays costs that are left after other insurance has paid – it is the "payer of last resort"

Affordable Care Act (ACA)-Mandated Changes: New Eligibility Factors

With the ACA, there will be required changes to income and household calculations for some groups. Medicaid will also provide healthcare coverage to select newly-required groups.

Modified Adjusted Gross Income (MAGI)

- **What is MAGI?**
  - Standardized income counting across all states
  - Used in both Medicaid and federal Marketplace program to determine eligibility for tax credits
  - Medicaid will change the way it counts:
    - Number of people in the household
    - Income
    - Assets

Immediate MAGI impact	Delayed MAGI impact	No MAGI impact
• New applicants • Adults • Parents and caretaker relatives • Children • Pregnant women	• Those approved for Medicaid before December 31, 2013 • Will be subject to new income counting when: • Redetermine Medicaid eligibility **OR** • Change reported	• Those exempt from MAGI calculation • Examples: Aged, Blind, Disabled, etc.

Basic Modified Adjusted Gross Income (MAGI):
Household Size & Income Changes

Applicant description	Household composition (as applicable)

Tax filer	• Tax filer
	• All tax dependents
	  • May include:
	  • Step -parents, -children, and -siblings
	  • Adult child tax dependent

Non-Filer & Certain Tax Dependents*	• Applicant
	• Spouse
	• Children
	• If applicant is child:
	  • Siblings
	  • Parents

*Tax Dependent defined as:
- Is other than a spouse, biological, adopted or step child of the tax filer
- Child claimed as tax dependent by non-custodial parent
- Child living with both parents who don't file joint return

Major income counting changes:

COUNT:

1. Taxable income
2. Income of children required to file a tax return

DO NOT COUNT:

1. Assets
   - i.e. bank account balance, stocks, retirement account, etc.
2. Non-taxable income
3. Income disregards (except tax deductions)

Rules for populations not using Modified Adjusted Gross Income (MAGI)

Who will not use MAGI?	• Aged • Blind • Disabled • Need long-term care or home and community-based services • Eligibility does not require income determination from Medicaid agency (i.e. Coverage under the Breast & Cervical Cancer Treatment Program) • Applicants for Medicare cost-sharing (i.e. Medicare Savings Program) • Former foster children under age 26 • Newborn babies with mothers on Medicaid (deemed newborns)

What income counts for "non-MAGI?"	• Current income counting & household composition rules remain in place
	• Asset limits continue to apply
	  • Certain assets excluded such as:
	  • Individual's home
	  • Household goods
	  • Personal items

Eligibility Exception:
Calculating Income for Nursing Facility Medicaid

- If institutionalized person has a spouse that does not reside in an institution ("community spouse")
  - Special income & resource provisions apply
  - Community spouse may maintain:
    - All of his/her personal income
    - Half of income from assets owned by both spouses
  - If this totals less than $1,939/month*, may keep some of institutionalized spouse income

*Effective 7/2013

New ACA-Created Eligibility Groups

- The Affordable Care Act (ACA) created new Medicaid groups the states must cover, including:
  - Former foster children
    - Under age 26
    - In foster care in Indiana and receiving Indiana Medicaid as of 18th birthday
    - Not subject to income limits until age 26
  - Children age 6-18
    - Up to 133% Federal Poverty Level (FPL)
    - Indiana already covers this group

New ACA-Created Medicaid Categories

- With the implementation of the Modified Adjusted Gross Income (MAGI):
  - Some eligibility categories ("aid categories") will change
    - Some categories will be combined and given new names
    - Category name changes will not impact benefits

Indiana Application for Health Coverage (IAHC) and Applying for Disability Medicaid

Changes for Indiana Application for Health Coverage

- Starting October 2013
- Applications for health coverage and other state benefits include:
  - Indiana Application for Health Coverage,
  - Indiana Application for Supplemental Nutrition Assistance Program (SNAP) & Temporary Aid to Needy Families (TANF) and
  - Healthy Indiana Plan Application
- Applications accepted:
  - Online (Recommended),
  - Phone,
  - Fax,
  - Mail, or
  - In person at local Division of Family Resources (DFR) offices

Disability Medicaid Application Process: effective June 1, 2014

Applications to Social Security Administration (SSA)

Exceptions:

Direct application to Indiana Medicaid without SSA determination if:

- Applicant is a child
- Applicant has a recognized religious objection to applying for federal benefits (e.g., Amish)
- Applicant moves to the M.E.D. Works medically improved category
- Applicant cites other "good cause" for not applying to SSA

Supplemental Security Income (SSI) Eligible

- State auto-enrolls in Medicaid

Social Security Disability Income (SSDI) Eligible

- Apply to Indiana Medicaid for verification of other eligibility factors
- Will not undergo medical review team (MRT) process

SSA Denial (determined non-disabled)

- Generally Medicaid ineligible
  - State will not initiate MRT process for applicant except in two cases (to be discussed)

New Medicaid Applications on the basis of disability

State requires Social Security Administration (SSA) application for disability determination*

- SSA application status checked through shared data file
- If no SSA application filed within 45 days of Medicaid application date:
  - Medicaid application denied

State initiates Medical Review Team (MRT) process

- If SSA determination received during MRT process:
  - State stops MRT
  - State defers to SSA decision

MRT determination applies pending SSA decision

- If the two conflict:
  - SSA overrides MRT

Process effective June 1, 2014

* Individuals receiving Medicaid on the basis of disability on June 1, 2014 will keep eligibility even if they do not have SSA determination. These individuals will be required to apply to SSA as a part of their next scheduled MRT progress report.

Exceptions to SSA Denial

Applicant with an SSA denial may undergo MRT process in the following circumstances:

- Change or worsening of old condition since SSA denial

OR

- A new condition

AND

1. More than 12 months have passed since denial
   - State will require applicant to re-apply/appeal to SSA

OR

2. Fewer than 12 months have passed since denial **and** SSA has refused to consider new evidence

Verifying Eligibility Information

PREVIOUS:

Applicant provides some paper verification documents at time of application

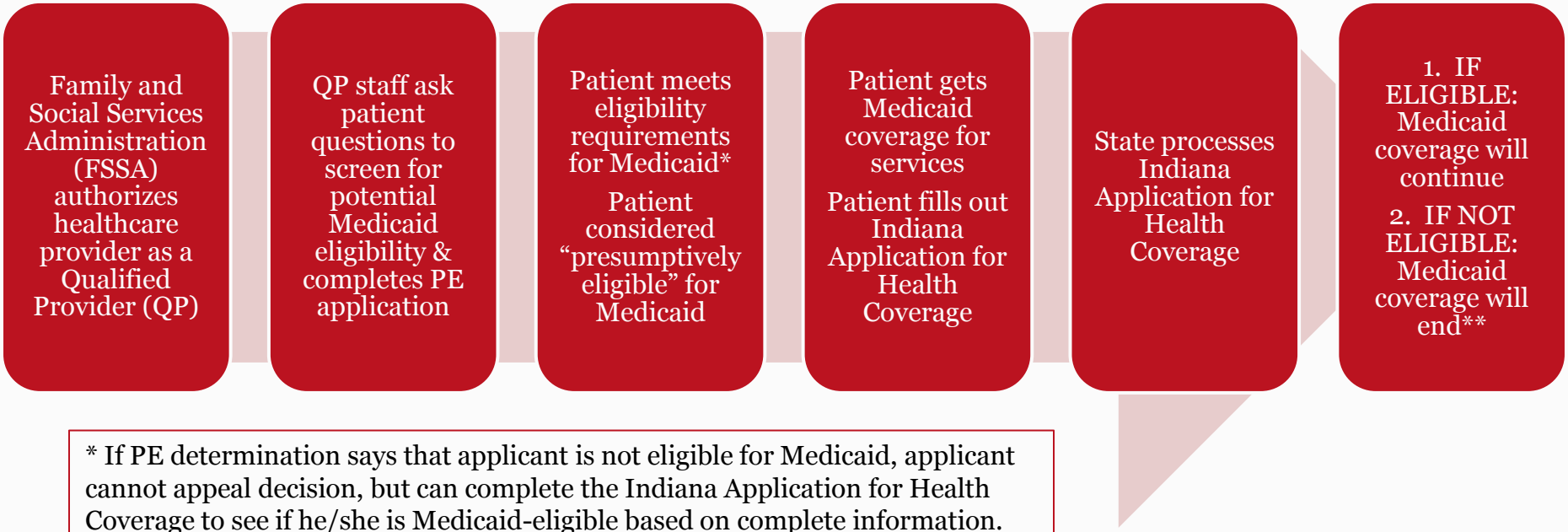
CURRENT:

1. Verify eligibility information using state & federal electronic data sources
2. Ask applicant for paper documentation ONLY if no electronic data or inconsistent with application

NOTE: Applicants **must** submit requested verification documents by the posted due date

Presumptive Eligibility (PE)

- **Overview:**
  - Allows qualified individuals to have services paid for by Medicaid pending the outcome of a full Medicaid determination
- **Process:**



* If PE determination says that applicant is not eligible for Medicaid, applicant cannot appeal decision, but can complete the Indiana Application for Health Coverage to see if he/she is Medicaid-eligible based on complete information.

** Provider will still be reimbursed for services provided during PE period.

Presumptive Eligibility (PE) Programs

PE for Pregnant Women: Managed Care

- Provides temporary coverage of prenatal care services (Package P only)
- Pregnant women can apply with doctors or clinics enrolled as qualified provider (QP)

Hospital Based PE: Fee for Service

- Effective 1/1/14 enrolled hospitals determine PE for:
  - Pregnant women (Package P only)
  - Children under 19
  - Low-income parents & caretakers
  - Family Planning Eligibility Program
  - Former foster children up to age 26

Eligibility Notices & Appeals

Regardless of whether an applicant is eligible for Indiana Medicaid, he or she can expect a notice to explain the decision. If the applicant disagrees with the decision, it is possible to file an appeal.

Eligibility Notices

- **Notice from:**
  - Division of Family Resources (DFR)
- **When Medicaid applicant or beneficiary will get notice:**
  - After application reviewed:
    - Approved
    - Denied
  - After changes in coverage:
    - Terminate coverage
    - Suspend coverage
    - Change in benefit package or aid category

Eligibility Appeals

- **What is an appeal?**
  - Applicant or beneficiary:
    - Disagrees with Medicaid agency decision
    - Asks Medicaid agency to re-evaluate decision in front of an Administrative Law Judge (ALJ)
- **What can be appealed?**
  - Termination of benefits, or
  - Suspension of benefits, or
  - Reduction of benefits
  - Delay in determining eligibility

After Being Determined Eligible for an Indiana Health Coverage Program (IHCP)

Eligibility Redeterminations

Eligibility Redeterminations

- **Purpose:**
  - To be sure that individuals with Medicaid are still eligible
- **How often:**
  - Every 12 months
- **Process:**
  - State checks if there is enough electronic data to renew eligibility
    - If yes: State will renew Medicaid
    - If no: State will contact enrollee for more information

Module #2 Review

- Having reviewed this module, you should now be able to:
  - Assess whether someone might be POTENTIALLY eligible for Medicaid
  - Tell a consumer what information he or she will need to provide as a part the Medicaid application
  - Explain consumer options to apply for health coverage through the State
  - Help a consumer know what to expect after the application is filed